Joint Commission Rules Tackle Infection Control

Hospitals will be required to have a surveillance program up and running by Jan. 1, 2010.

BY MARY ELLEN SCHNEIDER
New York Bureau

The Joint Commission has issued new requirements for hospitals in an effort to prevent infections from multidrug-resistant organisms, central line–associated bloodstream infections, and surgical site infections.

The requirements, which are part of the organization's 2009 National Patient Safety Goals for hospitals, include a 1-year phase-in period with full implementation by Jan. 1, 2010.

It is critical for hospitals to begin addressing the issue of health care–associated infections and to try to keep the problem from worsening, said Dr. Peter Angood, vice president and chief patient safety officer for the Joint Commission. "We're in a bit of a tight spot and we need to work our way out of it," he said.

The new infection control requirements build on an existing National Patient Safety Goal on health care–associated infections that had previously included only requirements for compliance with hand hygiene guidelines and had called on hospitals to manage serious infections as sentinel events. Those requirements will remain in place along with the new elements of the goal.

"Infection control is high on our priority list overall," Dr. Angood said.

Under the new 2009 requirements, hospitals are being asked to begin preparing to prevent infections resulting from multidrug-resistant organisms such as methicillin-resistant *Staphylococcus aureus*, *Clostridium difficile*, vancomycin-resistant enterococci, multidrug-resistant gram negative bacteria, and other epidemiologically important organisms.

Starting in January 2010, hospitals will need to conduct periodic risk assessments for acquisition and transmission of multidrug-resistant organisms, and educate staff and independent providers about prevention strategies and their roles. Hospitals also will be required to provide education about infection control strategies to patients and families who are infected or colonized with multidrug-resistant organisms.

Hospitals will be required to have a surveillance program up and running by Jan. 1, 2010, that is based on the hospital's risk assessment.

When indicated by the risk assessment, hospitals will need to implement a laboratory-based alert system to identify new patients with multidrug-resistant organisms, and an alert system to identify readmitted or transferred patients who have multidrug-resistant organisms.

The Joint Commission also has put new requirements in place to prevent central line–associated bloodstream infections and surgical site infections.

As part of the requirements related to central line–associated bloodstream infections, hospitals will be expected to use a catheter checklist and a standardized protocol for central venous catheter insertion and an all-inclusive standardized supply cart or kit for insertion of central venous catheters.

The requirements also call for the use of standardized protocols for maximum sterile barrier precautions during insertion of a central venous catheter and when disinfecting catheter hubs and injection ports before accessing the ports.

As part of its effort to prevent surgical site infections, the Joint Commission is requiring hospitals to conduct periodic risk assessments, select surgical site infection measures based on evidence, and evaluate the effectiveness of their prevention efforts. Also, hospital staff will need to measure infection rates for the first 30 days following most procedures and for the first year after procedures involving implantable devices.

The surgical site infection requirements were developed to be in line with well established guidelines and should help organizations move toward compliance with those guidelines, Dr. Angood said.

All of the new requirements related to health care–associated infections include a 1-year phase-in period, with milestones for planning, development, and testing throughout 2009. Allowing organizations to phase in complex requirements over the course of a year helps them to perform better by achieving concrete goals before full compliance is expected, Dr. Angood said.

Addressing health care–associated infections is a worthy goal, said Dr. Franklin Michota, who is director of academic affairs for the department of hospital medicine at the Cleveland Clinic. There is sufficient evidence to show a clinical benefit from implementing infection control strategies. "It's not an experiment to see if these things work," he said.

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Hospitals are likely to face some up-front costs when implementing the new requirements, Dr. Michota said, especially if they need to put a new educational process in place to prepare staff. For that reason, hospitals may be looking to involve hospitalists, who are already on the payroll, in a variety of activities related to preventing health care–associated infections, he said.

Hospitalists may be involved in developing process improvement plans, tracking requirements, or tracking infections. Those who are not involved on the quality side may be asked to champion changes at the floor level by modeling appropriate hand hygiene or compliance with contact precautions.

"Shining additional light on [health care–associated infections] is good," said Dr. Patrick J. Cawley, president of the Society of Hospital Medicine and executive medical director at the Medical University of South Carolina, Charleston.

The requirements for central line–associated bloodstream infections, in particular, are a significant step forward. There is clear evidence in the literature that compliance with central line placement protocols can significantly drive down infection rates, he said. "This is something we all should be doing anyway," Dr. Cawley said.

Although many hospitals have made infection control a priority, having these new requirements from the Joint Commission will help to elevate those efforts, he added.

The Joint Commission also has added new requirements to the goal for medication reconciliation. Hospitals are advised to provide a complete and reconciled list of the patient's medications directly to the patient and explain the list at the time of discharge. In those settings where medications were used minimally or for a short duration, such as the emergency department, the hospital is required to perform a modified medication reconciliation process.

For example, if a short-term course of an antibiotic is prescribed, the patient should be provided with a list containing the medications that the patient will continue using after leaving the hospital.

Also new in 2009 is a requirement to eliminate transfusion errors related to patient misidentification.

Before beginning a blood or blood component transfusion, hospital staff must match the patient to the blood during a two-person bedside verification process. In cases where two individuals are not available, a bar code or other automated technology can be used in place of one of the individuals, according to the Joint Commission. ■

Stressed Health Care Systems are Driving MRSA Spread

BY DENISE NAPOLI
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Overcrowding and understaffing of hospitals are two of the major underlying factors driving the spread of methicillin-resistant *Staphylococcus aureus* in this setting, according to a review.

Furthermore, "the economic benefits of downsizing health care systems are likely to have been offset by the increased burden of adverse events, such as MRSA," the authors wrote.

Archie Clements, Ph.D., of the division of epidemiology and social medicine at the University of Queensland (Australia), and his colleagues from the fields of mathematics, statistics, infection surveillance, and medicine, cited 140 studies in their review (Lancet Infect. Dis. 2008;8:427-34).

They concluded that the direct mechanisms through which hospital-acquired infections are spread—including a decrease in handwashing, less "cohorting" of patients (meaning patients interact with a large number of health care workers), and closer proximity of infected patients to noninfected patients—are themselves caused by a dearth of health care professionals and a surplus of patients.

For instance, in the case of handwashing—a known, simple, and inexpensive method to reduce the spread of MRSA dramatically—overworked health care staff are less likely to wash when indicated, according to several studies cited by the authors.

In one study, noncompliance was highest in cases of high "intensity of patient care," when there were more than 40 opportunities for handwashing per hour of care, compared with when there were fewer indications per hour (Ann. Intern. Med. 1999;130:126-30).

Additionally, the spread of methicillin-resistant *S. aureus* within a facility exacerbates overcrowding, as patients' stays are extended, which in turn fuels chronic understaffing.

"This contributes to a vicious cycle, where the occurrence of MRSA makes it more difficult to implement effective infection control strategies, leading to subsequent breakdowns in infection control and further increases in the incidence of MRSA," the authors wrote.

The number of patients seeking care, inpatient or otherwise, is not likely to decrease any time soon—an aging population in the developed world means that countries like Australia can anticipate a 70%-130% increase in hospital bed requirements by 2050, according to the review.

There is hope, however. The authors praised institutions in the Netherlands and Scandinavian countries, for example, for keeping MRSA infection down.

On the level of individual facilities, the researchers cited several studies wherein screening of new admissions for infection, isolation of high-risk patients, and use of more effective hand hygiene products have proved successful.

More studies need to be undertaken to determine the "most cost-effective MRSA control strategies for a given situation," they added.

The authors wrote that they had no conflicts of interest to disclose. ■